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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 19 January 2023 at 4.30 pm in Council Chamber - City Hall, Bradford

Members of the Committee – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRATS	Green
A Ahmed Godwin Humphries R Jamil Wood	A E Coates J A Glentworth	A Griffiths	C R Hickson

Alternates:

LABOUR	CONSERVATIVE	LIBERAL DEMOCRATS	Green
S Akhtar Shabir Hussain U H Khan J Lintern Mohammed	P W Clarke P G Sullivan	A Naylor	C Whitaker

VOTING CO-OPTED MEMBERS:
Susan Crowe - Bradford and Craven Co-Production Partnership
Trevor Ramsay - i2i Patient Involvement Network, Bradford District NHS Foundation Care Trust
Helen Rushworth - Healthwatch Bradford and District

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From: **To:**
Asif Ibrahim
Director of Legal and Governance
Agenda Contact: **Asad Shah**
Phone: 01274 432280. E-Mail: asad.shah@bradford.gov.uk

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director

whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Asad Shah - 01274 432280)

4. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. CANCER SERVICES AND PERFORMANCE 1 - 24

The report of the Chief Operating Officers, Bradford District and Craven Health and Care Partnership (**Document "T"**) provides an update on performance against the key cancer standards and actions being taken to improve performance as a follow on from the last report brought in 2019. This paper also includes an update on the early phase pilot of the Tackling lung cancer pilot and the subsequent Targeted Lung Health Check Programme.

Recommended –

(1) Note the current outcomes of the targeted lung cancer health checks project.

(2) Note the placed based initiatives being implemented to support improvement in update of cancer screening programmes.

(3) Note the current performance in cancer services in Bradford District and Craven, and the improvements being made to cancer services following the Covid-19 pandemic.

(janet.hargreaves@bradford.nhs.uk)

6. CONSULTATION ON PROPOSED CHANGES TO ADULT SOCIAL CARE NON-RESIDENTIAL CHARGES 25 - 44

The report of the Strategic Director, Health and Wellbeing (**Document "U"**) seeks the committee's comments on proposed changes to adult social care services non-residential charges from April 2023.

Recommended –

(1) That the Committee comments on the proposals as part of the wider consultation exercise being undertaken by the Health & Wellbeing Department, ensuring that due regard is made to the Council's public sector duty as set out in the Equality Act 2010.

(2) That the Committee's remarks be reported back to the Executive when making a decision on this issue at its meeting in February 2023

(Jane Wood – 01274 437312)

7. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2022/23 45 - 50

The report of the Director of Legal and Governance (**Document "V"**) presents the Committee's work programme 2022/23.

Recommended –

(1) That the Committee notes the information in Appendix A and considers any amendments or additions it may wish to make.

(2) That the Committee notes that the March meeting will take place on Wednesday 22 March 2023.

(2) That the Work Programme 2022/23 continues to be regularly reviewed during the year.

(Caroline Coombs – 01274 432313)

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Chief Operating Officers, Bradford District and Craven Health and Care Partnership to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on Thursday 19 January 2023

T

Subject: Cancer services and performance

Summary statement:

- To update on the early pilot for tackling lung cancer and the targeted lung health check programme
- To update on the uptake of cancer screening services and diagnosing cancers early to achieve better outcomes and quality of life for patients.
- To update on cancer performance at Bradford Teaching Hospitals NHS Foundation Trust and Airedale NHS Foundation Trust
- To update on the ongoing impact that the Covid pandemic has had on delivering cancer services including an update on implementation plans instigated to ensure continuation of cancer services at this time and post Covid recovery plans
- To highlight the number of proactive initiatives and developments in cancer services within primary, community and secondary care that are helping to tackle performance issues as well as addressing health inequalities

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Portfolio:

Healthy People and Places

Report Contact: Janet Hargreaves
Phone:
E-mail:
Janet.Hargreaves@bradford.nhs.uk

1. Summary

1.1 This report is for members of the Health Overview and Scrutiny Committee providing an update on performance against the key cancer standards and actions being taken to improve performance as a follow on from the last report brought in 2019. This paper also includes an update on the early phase pilot of the Tackling lung cancer pilot and the subsequent Targeted Lung Health Check Programme.

1.2 During Covid, cancer services remained a priority for the NHS and our colleagues worked to maintain services throughout and post the pandemic. As seen across all health and care services and health and care systems - regionally and nationally - Covid has presented major challenges in meeting our performance targets. One of the most significant impacts was a sharp reduction in the number of people coming forward and being referred urgently with suspected cancer and referred from cancer screening programmes, the latter of which were suspended at the height of the pandemic.

1.3 Our recovery from the pandemic is continuing at pace and for some of the targets we are in the top quarter for performance against the core NHS cancer standards. However, we recognise there are still areas where our performance has not recovered to the levels we would want it to - this is due to the significant pressures we are seeing in our urgent and emergency care system and partly due to patient choice (people not coming forward for treatment or not booking for an appointment under the two week wait process).

1.4 We recognise that for many people the worry of concerning symptoms that could potentially lead to a diagnosis of cancer need to be picked up sooner so that we can treat and care for people as soon as possible. This is why we have taken proactive steps to increase screening for lung, bowel, cervical and breast cancer using a range of innovative methods. This has resulted in around 34 people being identified with suspected lung cancer, a 57% increase in the number of people asking for a bowel cancer screening test to be sent out and a 58% increase in weekly screening rates for cervical cancer.

1.5 This paper aims to update the committee on the effects COVID had on our local cancer services, the recovery plans implemented and to present the transformational initiatives we have introduced to both recover and progress the services pre and post pandemic.

2. Background

Tacking lung cancer and targeted lung health check (TLHC) programme

2.1 The Tackling Lung Cancer Programme involved Lung Health Checks and Low Dose CT Scanning with three GP Practices who were identified by their high levels of social deprivation, smoking and lung cancer mortality rates:

The Ridge Medical Practice - Ward: Little Horton
Rooley Lane Medical Centre - Ward: Bowling and Barkerend
Bowling Highfield Medical Practice - Ward: Bowling and Barkerend

2.2 The service started on 29th July 2019 and by the end of January 2020, 1,593 patients had received their Lung Health Check; 591 patients had received a Low Dose CT scan

and had been informed of the outcome; 24 patients were upgraded on to the lung cancer pathway for further investigations; and 10 patients had been diagnosed with lung cancer with an agreed treatment plan in place.

2.3 The Lung Health Check also helped identify a significant increase in new COPD diagnoses, which were passed back to the GPs for long term support in the community.

2.4 The impact of this intervention was earlier diagnosis for patients which enabled more patients to have curative treatment (for those with cancer) and for those with COPD to receive earlier support with their condition.

2.5 We have now been selected as one of 23 pilot sites nationally for the NHS England funded targeted lung health check programme. We are the second site selected in West Yorkshire following on from North Kirklees and it is expected that by 2027 the programme will be expanded further to include Wakefield and Harrogate. In Bradford District and Craven (BD&C), TLHC is currently in progress across 38 practices in the area. These practices have been selected using data on smoking prevalence and other socio-economic factors linked to deprivation in those areas. The remaining practices will be part of the expansion, to enable full coverage across Bradford and Craven across 2023/2024.

2.6 People aged 55 – 74 who smoke or have ever smoked, and are registered with a GP in the area, will be invited for a TLHC with a specially trained nurse. If participants are eligible following the lung health check, people will be offered a CT scan at a mobile scanner unit in a community location such as a supermarket or leisure centre car park.

2.7 Data recorded from February to October 22 shows out of 1,129 participants in BD&C who had a CT scan, 34 patients have been identified with suspected cancer.

2.8 The full update report highlighting progress on the targeted lung health check programme, including case studies and examples of our approach to raise awareness of the checks, can be found at appendix one.

3. Cancer performance

3.1 Cancer performance against the key performance standards is closely monitored by our Bradford District and Craven Health and Care Partnership Board (a committee of the NHS West Yorkshire Integrated Care Board) linking closely with Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), and Airedale NHS Foundation Trust (AFT) at cancer specialty level.

3.2 The key metrics include performance against

- the **two week waits** (referral to assessment), the Two-Week Wait appointment system was introduced so that anyone with symptoms that might indicate cancer could be seen by a specialist as quickly as possible;
- **31 days** (time to first treatment) that has a target for 96% of patients to start any type of treatment for a new primary cancer within one month (31 days) from the decision to treat;
- **62 days** (referral to treatment) that has a target for all cancer treatment pathways is for at least 85% of patients to start their first treatment for cancer within two months (62 days) of an urgent GP referral;
- **backlog** (patients waiting 63 to 103 days and over 104 days); and

- performance against a **new 28 day Faster Diagnosis Standard (FDS)** that was introduced in April 2021 and officially monitored from October 2021. This standard requires 75% patients to receive a cancer diagnosis or the all clear within 28-days of referral.

3.3 Following a Scrutiny Chair's briefing on Tuesday 10 January 2023 it was agreed this paper would provide the core narrative to support the performance figures, with an opportunity for discussion during the meeting on Thursday 19 January 2023.

In light of the above we have shared performance information in the appendices. Please see table one in Appendix Two that shows the current national Cancer Waiting Times Standards.

3.4 NHS England future plans are to change the cancer waiting times standards and aims to streamline current existing targets into 3 overall targets:

- The 28-day FDS – People who have been urgently referred for suspected cancer, have breast symptoms, or have been picked up through cancer screening, have cancer ruled out or receive a diagnosis within 28 days.
- A 62-day referral to treatment standard – Patients who receive a cancer diagnosis after an urgent suspected cancer referral, referral for breast cancer symptoms, or via cancer screening should start treatment within 62 days of that initial referral.
- A 31-day decision to treat to treatment standard – Patients, regardless of how they came to be diagnosed with cancer, should receive their treatment within a month of a deciding to treat their cancer.

3.5 The old targets are being replaced to ensure that patients receive an earlier and faster diagnosis, whether or not they are diagnosed with cancer, and to provide a better experience of care so people have either a diagnosis and commence their treatment, or receive the "all clear". This is line with a broader approach being adopted by NHS England to streamline metrics that are covered by the 2023/24 priorities and operational planning guidance for the NHS. The guidance is available online https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/

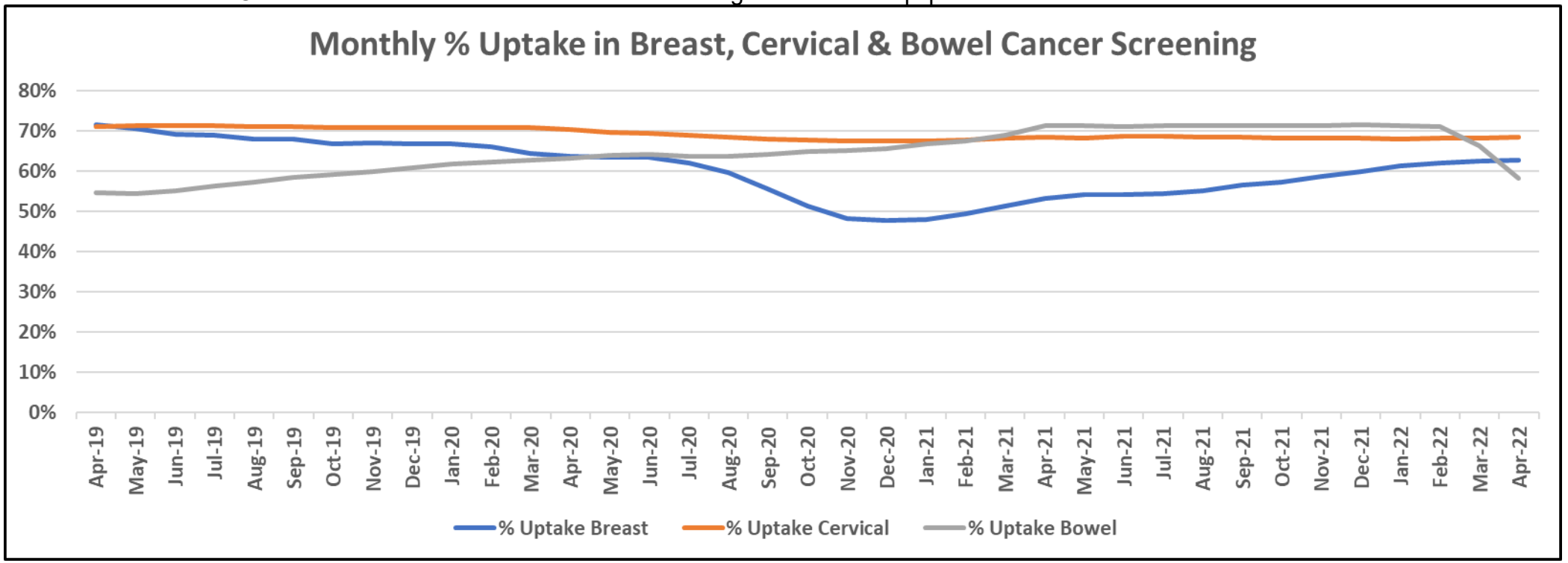
4. Main report

The report covers the three main areas of cancer, from cancer screening services; community and primary care, and secondary care, focusing on performance, issues and recovery plans.

Cancer Screening

4.1 March 2020 saw the suspension of the three national cancer screening services, breast, bowel and cervical. The chart below highlights the affect this had, particularly in breast, yet we can see that the uptake rates are increasing although more focused efforts need to concentrate on increasing responder rates, with progressing in response to this.

4.2 Focusing on the decline in the breast figures in 2020, this is a common theme related to the three-year breast screening and the areas being invited generally have low up take. Other factors that impacted our screening figures included additional time required for each appointment to ensure services were Covid safe and we encountered issues affecting some of our equipment.



4.3 Although cancer screening and the associated performance targets are the responsibility of NHS England and Public Health, our place-based partnership and our wider NHS West Yorkshire Integrated Care Board has taken an active role in implementing transformational projects, targeted at high deprivation and inequality areas in an attempt to increase the uptake of the cancer screening programmes. The next section of our report demonstrates the work we have done and the impact this has had.

4.4 Bowel cancer screening 'call for a kit' In 2021-2022 a project was implemented across Bradford District, to assist in the uptake rates of bowel cancer screening. The project aimed to develop a culturally sensitive model using a telephone-based intervention to encourage uptake of bowel cancer screening allowing people to use their preferred language to call for a kit.

4.5 The GP practices involved were situated in inner city Bradford, in seldom heard communities with high deprivation. People who had not taken the initial invitation to undertake a bowel cancer screen were contacted to explain the importance of the screen and talk through any concerns/anxieties people may have. This resulted in 1222 (57%) of people asking to have another test sent out, thereby increasing the response rate and overall success of the project.

4.6 Cervical Cancer Screening Behavioural Science and Nudge Theory Techniques Behavioural Science, also known as Behavioural Economics, is the study of human behaviour, including habits, actions, and intentions across the fields of psychology, economics, HR, and organisational behaviour.

4.7 Behavioural Science can be a very broad area of study, however for the purpose of increasing the uptake rates for cancer screening programmes this technique was implemented to focus on people's decision-making process to attend a screen; the factors that can influence this process and how these decisions vary.

4.8 The main objective was to trial Behavioural Science theories as a proof of concept in increasing the uptake of cervical cancer screening and in reducing inequalities in our area. If successful, this would contribute to system wide initiatives to reduce gaps in life expectancy where this correlates to deprivation and the early diagnosis cancers at stage 1 and 2.

4.9 A pilot implemented in 2021 in an area of high deprivation and health inequalities, demonstrated an increase in screening rates. The increase in weekly screening rates, based on 15 weeks before and after trial start date, were 58%

4.10 Following the pilot's success, this project is currently being rolled out across a further 16 practices in inner city Bradford and Keighley.

4.11 Breast cancer Working with GP Practices, the Pennine Breast Team are doing some focused work on

- Contacting all women from 53-55yrs who have not attended breast screening in the past.
- Giving people aged 51-53 a heads up that they should get ready for their invite for breast screening, if appropriate.

- Contacting those on the Learning Disability register, aged 50-70 and explore if they and their carers understand the process/will attend/ require a 'best interests' assessment.

4.12 The team are also doing some focused engagement work with local groups, carers and care facilities, refuges and women's centres and various other community-based services both directly and via social media.

4.13 Learning Disability (LD) and Autism Cervical Cancer Screening project Various reports over the past few years have identified significant inequalities in provision of and access to healthcare services for people with LD.

4.14 The 'Making Reasonable Adjustments to Cancer Screening' report by Public Health England (PHE) states that ladies with a learning disability are 29% less likely to take up cervical cancer screening compared to the 69% of the general population and that people with LD not only have poorer health than the general population but are more likely to die at a younger age. One of the reasons for this is due to lack of access to health services and barriers to the uptake of screening among people with a learning disability.

4.15 These barriers include the lack of easy read invitations and resources, difficulties using appointment systems, time pressures and mobility issues as well as communication difficulties. Research has also shown that;

- Patients are more likely to be ceased from breast and cervical screening programmes
- Screening professionals have little experience of supporting patients with LD
- Screening is not always considered as a high priority among family and carers
- Fear of screening can prevent patients from attending a screen

4.16 Cancer cervical screening uptake rates in Bradford District and Craven for people with LD is low, with only 30.02% of women taking the test, highlighting the need for intensive intervention with both workforce and the LD community.

4.17 The project will begin early 2023 and focus on both primary care workforce and learning disability and autism community to develop a transferable model, easy read information, education and awareness sessions. There may not be a significant increase to the uptake rates however people will have access to information to allow them to make an informed choice to have the screen or not.

4.18 Working with South Asian men in an attempt to increase cervical cancer screening uptake in women We are also currently working with Bradford University on an innovative research project to work with South Asian men in an attempt to increase cervical cancer screening uptake in women. This will involve working with elders, mosques, community groups etc to educate on the importance of the screen and support and encourage women to engage in the screening programme. **The project will begin in early 2023.**

4.19 In addition, working in collaboration with Cancer Research UK and West Yorkshire and Harrogate Cancer Alliance, we have identified trained Cancer Champions in the

majority of GP Practices across our place. This allows for a point of contact for people to ask questions, discuss concerns etc around cancer, in particular cancer screening and help to encourage people to take their screen.

5. Cancer services and support within our hospitals

5.1 Cancer Services and Covid During Covid cancer services remained an absolute priority for the NHS and staff worked to maintain services throughout and post the pandemic.

5.2 On 23 March 2020, the NHS issued national guidance to support clinicians on treatment decision-making and prioritisation, and to inform conversations with patients on treatment plans:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf

5.3 On 30 March 2020, national guidance recommended that urgent consideration should be given to consolidating cancer surgery in a Covid-free hub, with centralised triage to prioritise patients based on clinical need:
https://www.england.nhs.uk/coronavirus/publication/advice-to-trusts-on-maintaining-cancer-treatment-during-the-covid-19-response/

5.4 Both Bradford (BTHFT) and Airedale Hospitals (ANHSFT) introduced a number of processes in place to assist with this, which included:

- Supporting the setting up of a Covid Centre in Harrogate led by a respiratory clinical lead.
- Daily meetings implemented for outpatient appointments to assess daily needs of trusts delivering services and escalating issues.
- Dedicated wards for patients with Covid-19 to protect them and others.
- Use of theatre capacity to help increase ITU capacity.
- Hot and cold spaces within the hospital to help reduce in spread of virus.
- Patients categorised nationally within guidance for surgery and treatments.
- National guidance on the use of aerosol generated procedures affected endoscopy.
- Infection control guidance in line with national policies, which reduced capacity in many areas, such as theatre times due to the in depth cleans etc required in-between patients
- A Clinical Nurse Specialist (CNS) helpline was introduced for patients to cover all sites and staffed by a CNS who had previously worked for Macmillan, to signpost and help people access support - often non-clinical and pastoral support.
- Use of Yorkshire Clinic to provide a Covid-19 free hub for patients receiving cancer treatment and to provide additional capacity for our health and care system.
- Implemented priority guidance for chemotherapy patients in line with national guidance.
- Use of chemotherapy buses to help provide social distancing when delivering chemo and reduce footfall on the hospital site.
- Adhered to West Yorkshire and Harrogate Cancer Alliance Cancer Covid Standard Operating Procedure.

5.5 In addition, processes were built on or introduced which include:

- Remedial Action Plans to help redesign cancer services to benefit patients and increase cancer services overall resilience

- Patient Tracking Lists (PTL) which collects data used to monitor the performance of acute trusts in respect of the national cancer 62-day and faster diagnosis standards. This weekly snapshot shows the number of patients on the cancer 62 day pathway, including those at risk of breaching the 62-day standards.

- 62 day audits, to identify all patients who may possibly or have breached 62 days on the cancer pathway continue to be investigated. Due to their complex health issues it may take longer to detect the actual cancer site. In addition, patients may also have other non-cancer clinical appointments that may delay the cancer appointments. For these people both hospital sites conduct breach analysis which is discussed at appropriate governance or business meetings.

- Introduction of a West Yorkshire and Harrogate Cancer Alliance (WY&H CA) 'cancer Covid PTL' which provided an understanding of the number of patients who were on a pathway affected by Covid. This included the backlog of patients without a diagnosis and who are waiting for diagnostic tests and those with a cancer diagnosis who were waiting for treatment. The PTL also supported the creation of a list of patients needing time-critical cancer surgery for which there was no capacity at Bradford or Airedale Hospitals but could be offered treatment at an alternative provider or hub within West Yorkshire and Harrogate.

- Cancer Care Navigators, which supported the patients through the pathway and assisted the Clinical Nurse Specialists by reducing their administrative workload to allow them to concentrate on clinical duties

- BTHFT and ANHSFT rapid diagnostic clinics (non-site specific clinics), for people whose symptoms do not meet the national 2 week with fast track referral criteria, there is a joint weekly community hub clinic at for people with vague but concerning symptoms. This improves the diagnostic experience for patients, providing faster diagnosis and if symptoms are not cancer then the team refer onto the correct pathway. Patients can now also self-refer into one of our hubs which is addressing health inequalities in access to care.

6.1 BTHFT Cancer Standards.

Cancer Standards - Overview by Indicator – BTHFT

Measure	Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
14 day GP referral for all suspected cancers	93%	96.2%	91.6%	95.0%	95.0%	95.4%	92.9%	96.1%	96.3%	94.3%	97.0%	95.8%	94.6%	91.8%	87.8%	93.4%	*95.2%*	*91.5%*
14 day breast symptomatic referral	93%	99.3%	99.5%	97.4%	84.5%	88.0%	98.4%	98.6%	100.0%	100.0%	100.0%	94.2%	96.6%	99.2%	99.1%	99.1%	*97.2%*	*94.4%*
31 day first treatment	96%	88.6%	90.7%	97.3%	95.6%	97.3%	91.1%	94.4%	93.9%	94.5%	96.1%	94.8%	96.3%	89.7%	94.4%	96.9%	*94.8%*	*92.1%*
31 day subsequent drug treatment	98%	100.0%	100.0%	97.4%	98.0%	98.1%	93.3%	95.3%	98.5%	97.0%	100.0%	97.8%	92.9%	94.0%	96.4%	98.3%	*98.1%*	*91.2%*
31 day subsequent surgery treatment	94%	81.6%	92.0%	92.3%	86.3%	92.3%	82.2%	77.5%	90.7%	77.1%	89.5%	90.2%	89.1%	86.3%	95.1%	92.7%	*78.9%*	*75.7%*
62 day GP referral to treatment	85%	82.0%	68.6%	76.9%	81.4%	88.0%	71.8%	75.2%	78.4%	80.3%	81.6%	79.1%	77.9%	83.6%	76.8%	73.3%	*72.3%*	*65.4%*
62 day screening referral to treatment	90%	71.0%	96.0%	83.8%	80.0%	82.7%	63.6%	62.5%	72.5%	72.4%	81.8%	88.6%	81.0%	85.4%	70.6%	83.3%	*78.9%*	*90.3%*
62 day consultant upgrade to treatment		55.6%	100.0%	60.0%	66.7%	66.7%	18.2%	66.7%	69.2%	71.4%	100.0%	55.6%	66.7%	100.0%	100.0%	33.3%	*80.0%*	*61.5%*

Cancer Wait Time Improvement

Internal and partnership work to improve systems which impact on patient pathways continues. This work includes:

- On-going review of clinical pathways, with improvement support to pathway redesign in line with best practice timed pathways, cancer milestones, improving quality, patient experience and inequalities.
- Tiered 1 & 2 escalation process has been extended to include the recovery of cancer 62 day waits delivery backlog. This is now being monitored with Trust performance increasing to 3.78% which is still within required levels.
- Work is underway to prepare and embed monitoring of the proposed new cancer standards alongside existing standards in order to capture overall Trust performance.
- Working with patients to reduce delays and did not attends (DNAs). For example, the wording on patient information leaflets and letters has been updated to ensure consistency and promote earlier attendance so patients are better informed of what the 2 week wait pathway means.
- Continued implementation of service development plans which include tele-dermatology (using a specialist camera to take pictures of skin conditions), pathway navigation roles, non-site specific pathways, and digital remote monitoring.
- Implementation of NG12 and FIT testing (to detect colorectal cancers), and changes to referral forms for Gynaecology and Urology in partnership with primary care and supported by the Local Medical Committee (GP representative committee) to improve the quality of fast track referrals ensuring patients have timely identification of their suspected cancer.
- Establishment of a cancer data group to collaborate and oversee implementation of several data and digital requirements that will support cancer services.
- Appointment of a personalised care lead and progression of health needs assessment and community rehabilitation work.
- Workforce development initiatives with external partners to develop student nurse placements and cancer nurse specialist roles.

6.2 Please refer to Appendix Three for a more detailed breakdown of performance against the standards.

7.1 AFT Cancer Standards.

Cancer Standards - Overview by Indicator – ANHSFT

Measure	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22		Oct-22	Nov-22
14 day GP referral for all suspected cancers	93%	93.2%	92.7%	91.7%	78.2%	83.4%	92.7%	92.6%	94.8%	92.8%	91.3%	94.8%	92.0%	90.3%	87.8%	88.8%		86.0%	82.2%
14 day breast symptomatic referral	93%	95.9%	90.2%	97.1%	31.7%	41.0%	62.5%	69.3%	93.8%	89.8%	95.1%	98.8%	97.1%	92.6%	98.5%	94.4%		100.0%	93.5%
31 day first treatment	96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.9%	98.8%	98.9%	100.0%	98.9%	98.8%	100.0%	100.0%	97.3%		96.4%	99.0%
31 day subsequent drug treatment	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	97.2%	100.0%	100.0%	96.9%	100.0%	100.0%		100.0%	100.0%
31 day subsequent surgery treatment	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	90.0%
62 day GP referral to treatment	85%	73.3%	86.7%	75.6%	78.2%	78.3%	80.0%	80.0%	83.3%	85.1%	85.9%	78.4%	64.0%	80.4%	70.6%	84.4%		88.2%	82.9%
62 day screening referral to treatment	90%	100.0%	50.0%	0.0%	100.0%	100.0%	75.0%	50.0%	100.0%	81.3%	40.0%	71.4%	25.0%	100.0%	75.0%	66.7%		33.3%	66.7%
62 day consultant upgrade to treatment		66.7%	37.5%	75.0%	37.5%	87.5%	100.0%	72.7%	100.0%	83.3%	53.8%	71.4%	25.0%	62.5%	86.7%	100.0%		60.9%	57.1%

Cancer Wait Time Improvement

Internal and partnership work to improve systems which impact on patient pathways continues. This work includes the following, some of which are consistent with BTHFT due to our partnership working:

- On-going review of clinical pathways, with improvement support to pathway redesign in line with BPTP, cancer milestones, improving quality, patient experience and inequalities.
- Weekly cancer PTL meeting to discuss patients over 62 days and discussed at OP level and at Cancer Alliance biweekly meeting.
- Capacity and demand work to inform future planning aligned to cancer wait time standards and national priorities.
- Working with patients to reduce delays and did not attends (DNAs). For example, the wording on patient information leaflets and letters has been updated to ensure consistency and promote earlier attendance so patients are better informed of what the 2 week wait pathway means.
- Continued implementation of service development plans which include pathway navigation roles, non-site specific pathways, and digital remote monitoring.
- Implementation of NG12 and FIT testing (to detect colorectal cancers), and changes to referral forms for Gynaecology and Urology in partnership with primary care and supported by the Local Medical Committee (GP representative committee) to improve the quality of fast track referrals ensuring patients have timely identification of their suspected cancer.
- Additional admin and clinical staff to help with the management of the Patient Tracking List and escalation process; and to implement Personalised Care interventions to help support Cancer Care Reviews in Primary Care.
- Workforce development initiatives with external partners to develop cancer nurse specialist roles.
- Service Improvement Lead in post to help develop and implement new ways of working to ensure people living with and beyond cancer have an improved experience and help support self-supported management.

8. **Contribution to corporate priorities**
Not applicable

9. **Recommendations**

Members are asked to

- Note the current outcomes of the targeted lung cancer health checks project
- Note the placed based initiatives being implemented to support improvement in update of cancer screening programmes
- Note the current performance in cancer services in Bradford District and Craven, and the improvements being made to cancer services following the Covid-19 pandemic.

10. **Background documents**

Not applicable

11. **Not for publication documents**

None

12. **Appendices**

Appendix One: Targeted Lung Health Checks
Appendix Two: National Cancer Waiting Time Standards
Appendix Three: BTHFT cancer performance standards
Appendix Four: AFT cancer performance standards

12.1 Appendix One

Appendix One
Targeted lung health c

12.2 Appendix Two

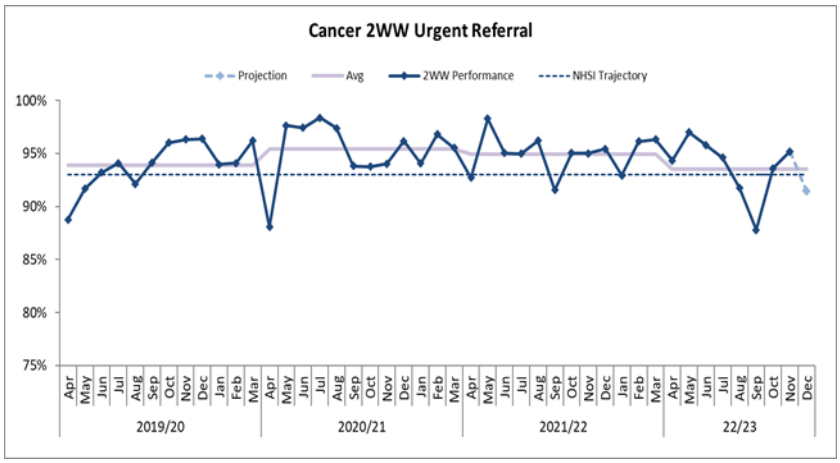
Table One: National Cancer Waiting Time Standards

2 week wait targets - This standard sets a time limit of two weeks to be seen by a specialist when referred urgently for further investigation. It measures the time from	
Urgent referral for suspected cancer to first outpatients attendance	Operational standard of 93%.
Referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment	Operational standard of 93%.
28 day Faster Diagnosis target – commenced April 2020	
The introduction of this new cancer diagnosis standard is designed to ensure that patients find out within 28 days whether or not they have cancer.	Operational standard from October 2021 is 75%.
31 day targets	
A maximum one month (31 day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers	Operational standard of 96%
A maximum 31 day wait for subsequent surgery treatment	Operational standard of 94%
A maximum 31 day wait for subsequent radiotherapy treatment	Operational standard of 94%
A maximum 31 day wait for subsequent anti-cancer drug regimen treatment	Operational standard of 98%
62 day wait targets	
Maximum two months from urgent referral for suspected cancer to first treatment	Operational standard of 85%
Urgent referral from an NHS Cancer Screening Programme for suspected cancer to first treatment -	Operational standard 90%
104 days – a quality improvement standard for managing 'long waiting cancer patients' on a 62 day pathway Any cancer patients waiting 104 days or more from referral to the first definitive treatment should be reviewed to identify any avoidable nonclinical delays An effective process should be in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a patient coming to harm due to those delays.	

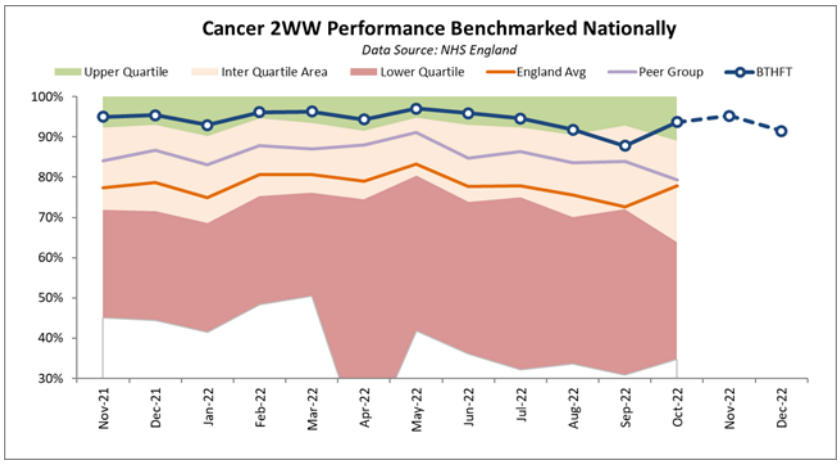
12.3 Appendix Three – BTHFT Cancer Performance Standards

A3a Cancer 2 Week Wait

Cancer 2WW performance (Target 93%)



2WW National Comparison



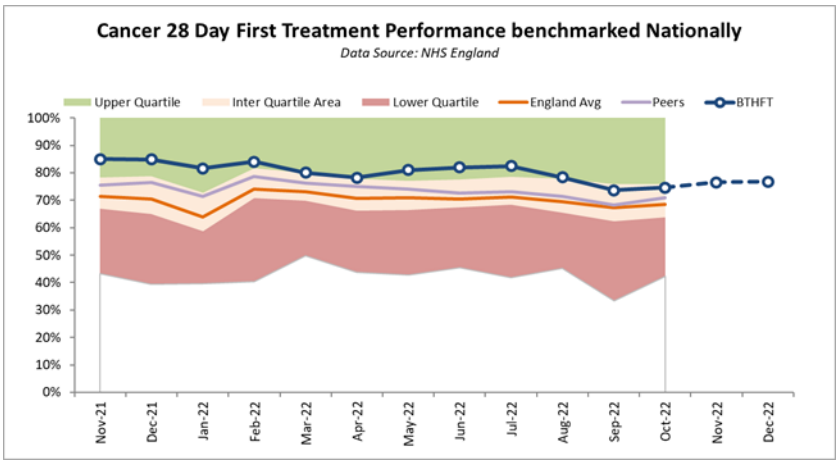
2WW Performance by Tumour Group

Site	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	*Nov-22*	*Dec-22*
TRUST	96.2%	91.6%	95.0%	95.0%	95.4%	92.9%	96.1%	96.3%	94.3%	97.0%	95.8%	94.6%	91.8%	87.8%	93.6%	95.20%	91.48%
Breast	100.0%	100.0%	97.5%	94.6%	93.1%	96.7%	97.6%	97.0%	98.2%	99.4%	95.9%	96.5%	99.0%	97.5%	97.0%	97.56%	96.53%
Gynae	97.7%	92.9%	89.1%	96.2%	94.2%	89.5%	94.1%	94.2%	94.0%	93.7%	87.0%	92.4%	98.7%	94.6%	96.6%	96.05%	93.02%
Haematology	100.0%	100.0%	100.0%	95.0%	100.0%	89.5%	90.0%	96.6%	90.9%	100.0%	100.0%	94.1%	100.0%	95.7%	100.0%	75.00%	55.56%
Head & Neck	98.8%	96.1%	95.5%	96.6%	95.6%	97.2%	96.2%	95.2%	93.6%	95.4%	96.6%	92.9%	96.3%	97.0%	97.4%	96.70%	90.41%
Lower GI	92.9%	87.9%	91.5%	90.9%	93.3%	85.4%	95.5%	94.4%	84.3%	96.4%	97.0%	91.3%	67.6%	56.9%	80.1%	87.35%	83.28%
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%
Other	100.0%	94.7%	100.0%	100.0%	100.0%	80.6%	97.7%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	98.1%	91.2%	89.66%	94.83%
Skin	95.5%	88.2%	96.3%	96.0%	96.1%	94.1%	97.3%	99.1%	97.5%	97.4%	96.8%	95.4%	96.5%	99.0%	99.3%	99.60%	98.16%
Upper GI	92.4%	89.7%	93.7%	89.6%	98.2%	94.5%	90.3%	91.9%	88.2%	94.0%	95.6%	96.0%	82.8%	75.9%	85.5%	92.47%	87.80%
Urology	98.8%	97.9%	98.4%	99.3%	97.7%	99.0%	97.8%	99.3%	99.2%	98.3%	96.4%	97.8%	95.2%	96.7%	97.9%	97.92%	89.71%

Prolonged high referral rates, increased patient volumes following successful awareness campaigns, and patient concordance (where patients choose not to attend an appointment within 2 weeks for a number of reasons personal to them) has presented a sustained challenge to our performance. Actions listed in 6.1 will continue to address this.

A3b Cancer 28 Day Faster Diagnosis

28 Day National Comparison – BTHFT



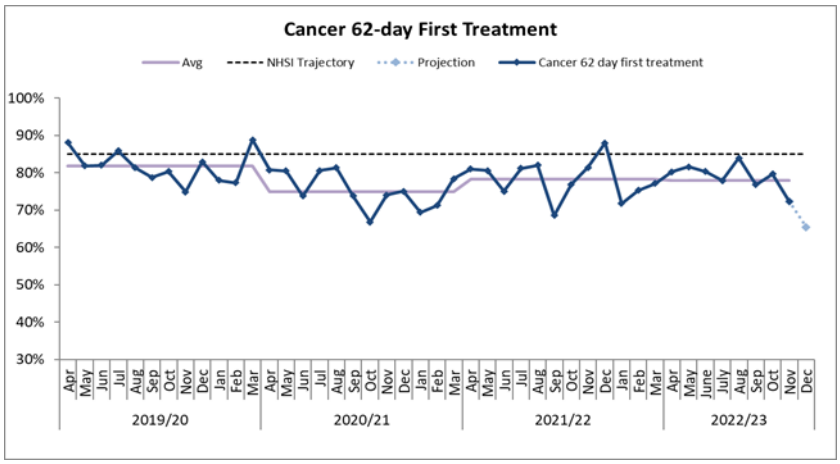
28 Day Faster Diagnosis Standard (FDS)

Site	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
TRUST	83.3%	81.9%	84.3%	85.3%	84.3%	81.7%	83.2%	79.9%	79.3%	82.0%	81.5%	81.5%	77.9%	72.5%	73.8%	76.5%	76.8%
Breast	100.0%	98.3%	98.5%	98.2%	98.1%	98.1%	98.8%	97.0%	97.9%	98.7%	99.5%	97.4%	98.0%	99.0%	100.0%	98.1%	98.0%
Gynae	75.8%	80.2%	66.7%	74.5%	68.5%	57.8%	49.5%	57.3%	53.6%	55.2%	56.0%	47.9%	48.5%	50.6%	62.3%	62.6%	51.4%
Haematology	78.3%	30.4%	83.3%	60.0%	82.6%	61.1%	75.0%	41.2%	44.4%	43.5%	52.6%	50.0%	44.0%	42.9%	50.0%	34.8%	40.9%
Head & Neck	75.0%	74.6%	81.3%	83.6%	86.2%	80.1%	71.6%	75.3%	76.0%	81.3%	81.1%	75.4%	79.4%	64.6%	65.3%	70.3%	73.6%
Lower GI	74.7%	64.6%	78.5%	78.7%	83.7%	76.2%	83.0%	71.4%	72.8%	78.5%	72.8%	74.2%	60.1%	58.6%	46.1%	58.6%	59.8%
Lung	81.0%	94.4%	75.0%	87.5%	83.8%	90.3%	88.6%	86.1%	84.8%	75.0%	85.7%	88.6%	92.5%	96.8%	88.2%	88.9%	91.7%
Other	91.7%	93.8%	94.7%	89.5%	80.0%	87.0%	86.4%	75.0%	81.8%	72.7%	61.1%	88.9%	92.3%	79.7%	75.0%	69.6%	83.8%
Skin	89.5%	90.8%	85.9%	85.1%	82.4%	80.5%	91.5%	86.0%	83.3%	85.1%	88.9%	91.3%	88.5%	78.5%	84.3%	87.3%	86.1%
Upper GI	76.5%	77.1%	88.2%	78.9%	86.0%	81.6%	68.0%	70.0%	63.6%	77.5%	79.7%	69.2%	67.1%	74.2%	82.2%	75.7%	71.3%
Urology	73.6%	81.2%	83.0%	90.3%	76.6%	72.6%	72.7%	75.9%	79.3%	75.9%	72.2%	81.7%	71.1%	61.5%	72.5%	69.0%	70.9%

Trust performance dipped below the 75% target in October 2022 and is expected to recover in November to above target levels, with the performance projected to further sustain the recovery through December at over 75%. The recovery was due to improved capacity across several tumour groups.

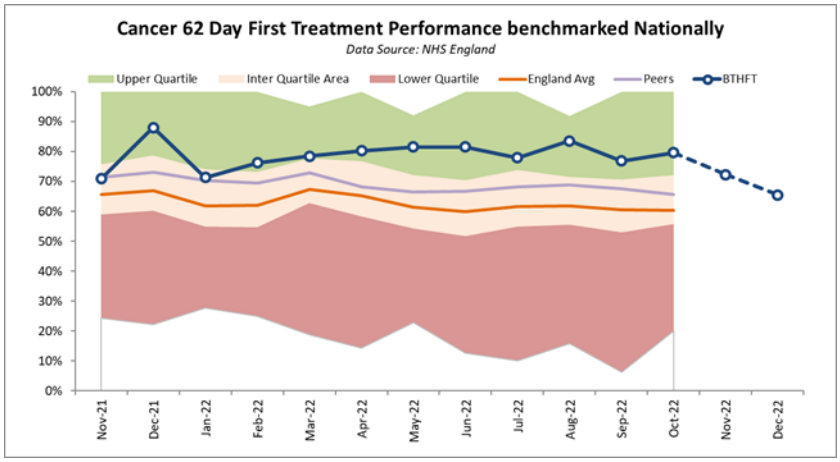
A3C Cancer 62 Day First Treatment

62 Day First Treatment performance (Target 85%)

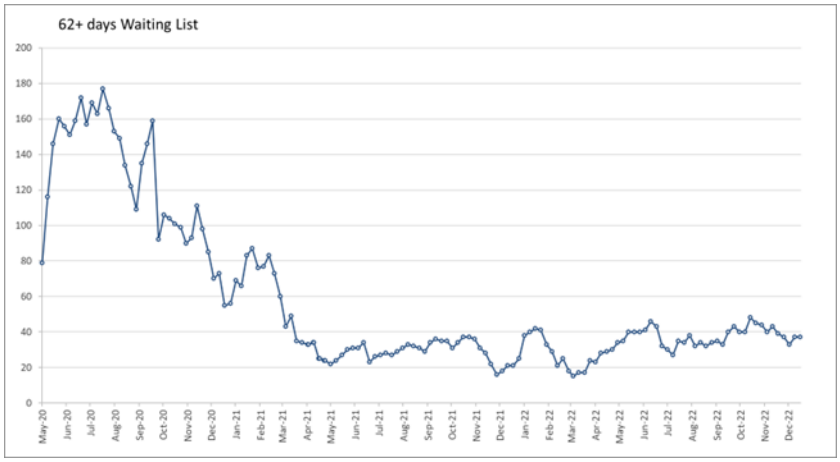


62 Day First Treatment performance - National

Comparison



Patients Waiting Over 62 Days



62 Day First Treatment performance by Tumour Group

Site	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	*Nov-22*	*Dec-22*
TRUST	82.0%	68.6%	76.9%	81.4%	87.98%	71.8%	75.2%	78.4%	80.3%	81.6%	80.4%	77.9%	83.6%	76.8%	79.6%	72.3%	65.4%
Breast	100.0%	86.7%	100.0%	84.0%	100.0%	78.6%	87.0%	100.0%	81.8%	92.3%	96.4%	92.3%	100.0%	86.7%	100.0%	91.7%	86.7%
Gynae	71.4%	44.4%	100.0%	60.0%	100.0%	80.0%	80.0%	50.0%	28.6%	14.3%	55.6%	100.0%	60.0%	66.7%	66.7%	55.6%	50.0%
Haematology	100.0%	100.0%	84.6%	66.7%	100.0%	66.7%	77.8%	66.7%	100.0%	61.5%	83.3%	40.0%	83.3%	100.0%	42.9%	83.3%	66.7%
Head & Neck	42.9%	20.0%	66.7%	35.7%	50.0%	20.0%	34.8%	66.7%	62.5%	30.8%	68.4%	35.3%	57.1%	46.2%	66.7%	36.4%	53.8%
Lower GI	62.5%	37.5%	72.7%	57.1%	100.0%	90.9%	50.0%	50.0%	50.0%	83.3%	61.5%	42.9%	20.0%	25.0%	61.5%	50.0%	45.5%
Lung	70.0%	25.0%	16.7%	40.0%	0.0%	40.0%	33.3%	33.3%	100.0%	60.0%	44.4%	0.0%	11.1%	14.3%	0.0%	0.0%	20.0%
Other			0.0%	66.7%	100.0%	100.0%	50.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%		0.0%	100.0%
Skin	97.1%	88.2%	100.0%	90.7%	94.4%	81.5%	97.2%	100.0%	94.1%	100.0%	97.1%	96.8%	100.0%	89.3%	93.0%	90.6%	91.7%
Upper GI		20.0%	22.2%	100.0%	85.7%	37.5%	25.0%	100.0%	75.0%	100.0%	13.3%	33.3%	80.0%	36.4%	36.4%	50.0%	0.0%
Urology	64.7%	73.7%	75.0%	88.4%	90.9%	81.5%	77.5%	78.6%	91.2%	86.2%	88.6%	95.0%	85.7%	90.2%	77.2%	79.5%	76.3%

Performance has continued below target at 79.65% for October as high referral volumes remain a challenge as patients progress through the pathway however the Trust has continued to perform in the upper quartile and above the National average.

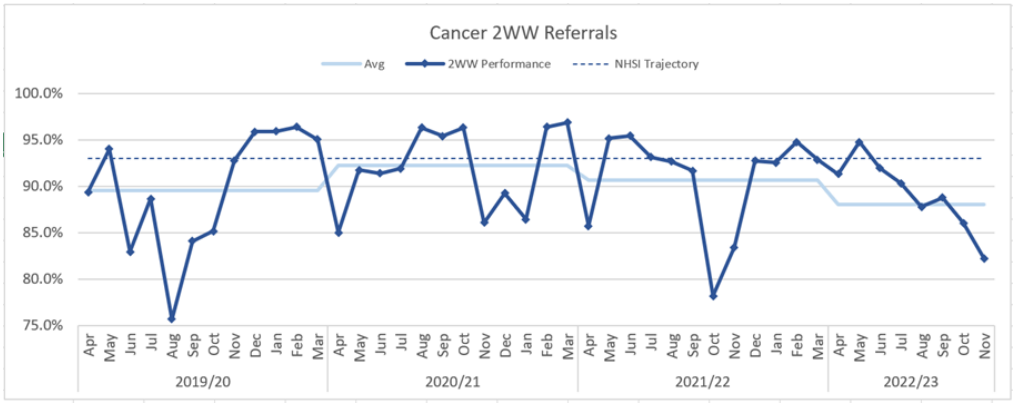
Pressure on diagnostic pathways has been a significant impact on the 62 day position recently with challenges for radiology managing the increase in requests having an effect on a number of tumour groups. The Cancer team continue to support with patient concordance issues working with patients to reduce wait times and DNA's which will begin to improve performance given that many tumour groups do have capacity to treat once these issues have been resolved.

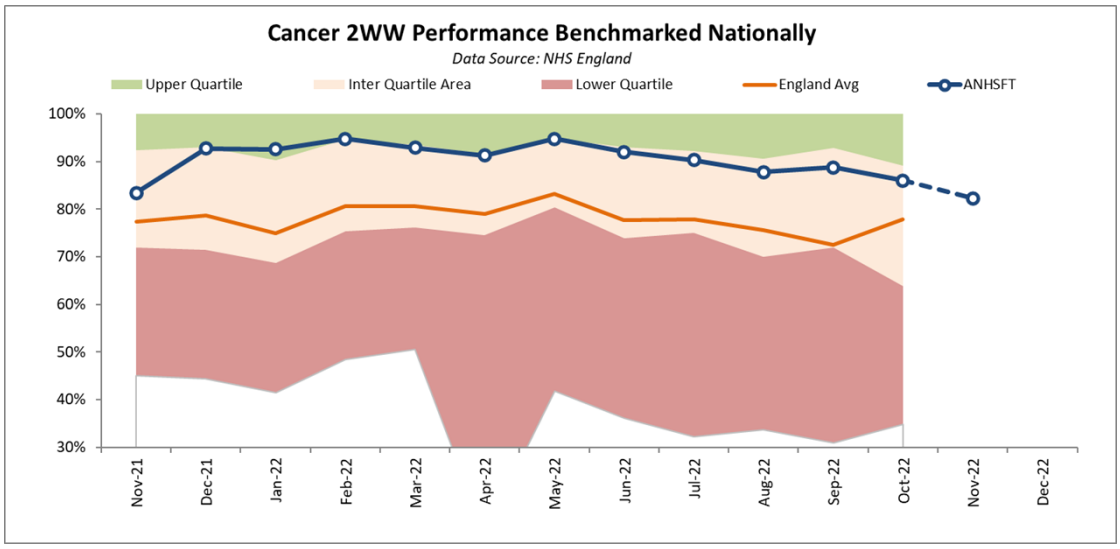
Continued implementation of service development plans as outlined in 6.2 will also support overall cancer wait time delivery.

12.4 Appendix Four – AFT Cancer Performance Standards

A4a Cancer 2 Week Wait

Cancer 2WW performance (Target 93%)





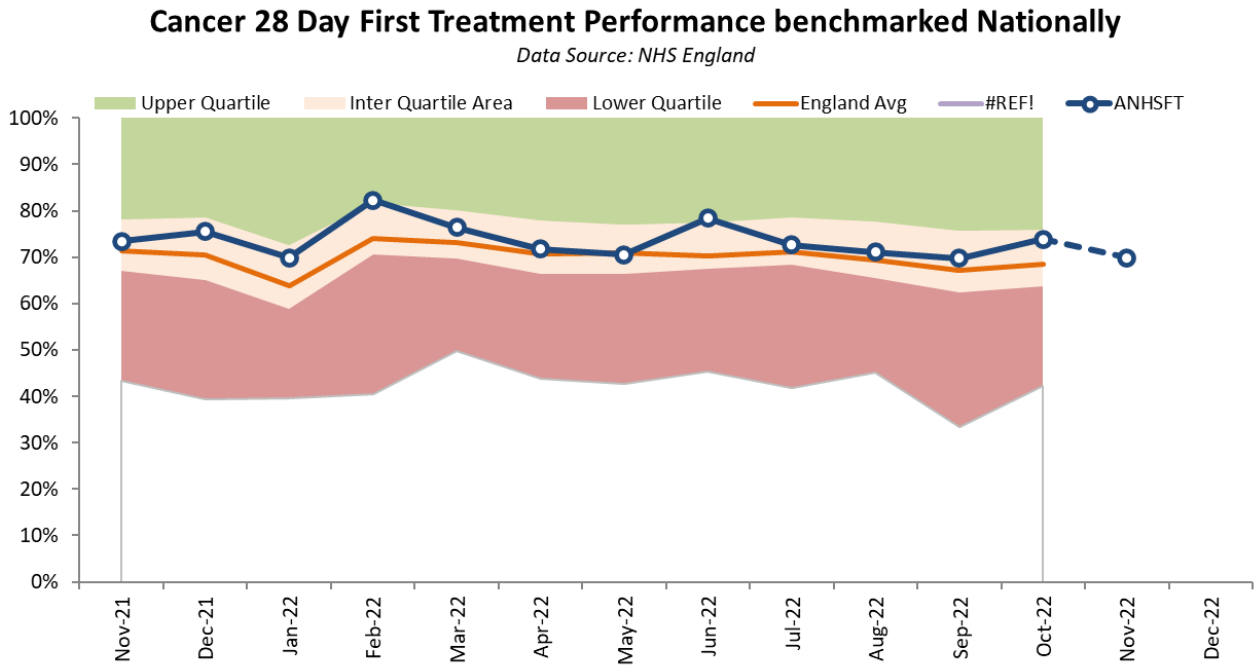
Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Overall Trust Position	93.2%	92.7%	91.7%	78.2%	83.4%	92.7%	92.6%	94.8%	92.8%	91.3%	94.8%	92.0%	90.3%	87.8%	88.8%	86.0%	82.2%
NSS (Non-site specific)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast	94.2%	94.4%	96.1%	35.9%	52.1%	86.0%	88.0%	96.7%	89.8%	99.1%	96.7%	95.3%	91.7%	100.0%	100.0%	100.0%	97.3%
Gynaecology	88.6%	98.7%	98.9%	97.6%	97.1%	97.0%	91.5%	100.0%	96.8%	95.3%	96.7%	95.7%	94.1%	94.4%	96.2%	96.3%	97.8%
Haematology	100.0%	81.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Head & Neck	92.3%	100.0%	100.0%	87.5%	100.0%	100.0%	95.0%	100.0%	88.9%	100.0%	92.0%	100.0%	95.2%	100.0%	83.3%	100.0%	95.0%
Lower GI	88.0%	83.1%	80.3%	84.1%	81.8%	88.2%	92.1%	85.5%	85.9%	76.3%	89.5%	81.5%	83.9%	65.2%	68.6%	61.2%	56.3%
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	91.7%	100.0%	96.4%	84.6%	100.0%	87.5%	100.0%	100.0%
Upper GI	97.8%	96.2%	87.2%	91.3%	88.9%	96.9%	91.2%	95.9%	95.9%	94.3%	93.2%	92.4%	91.7%	93.7%	90.3%	89.5%	82.2%
Urology	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%

2WW Performance by Tumour Group

There has been a sustained increase in referrals, particularly in gastrointestinal, since April 2022 and a number of these patients require an outpatient assessment prior to their test. In addition, 29% of patients cannot attend their appointments within 2 weeks. Additional clinic capacity and staffing is helping to support this demand.

A4b Cancer 28 Day Faster Diagnosis

28 Day National Comparison – ANHFT



Performance in October 2022 places the Trust in the upper quartile, significantly above peer group and above the England average.

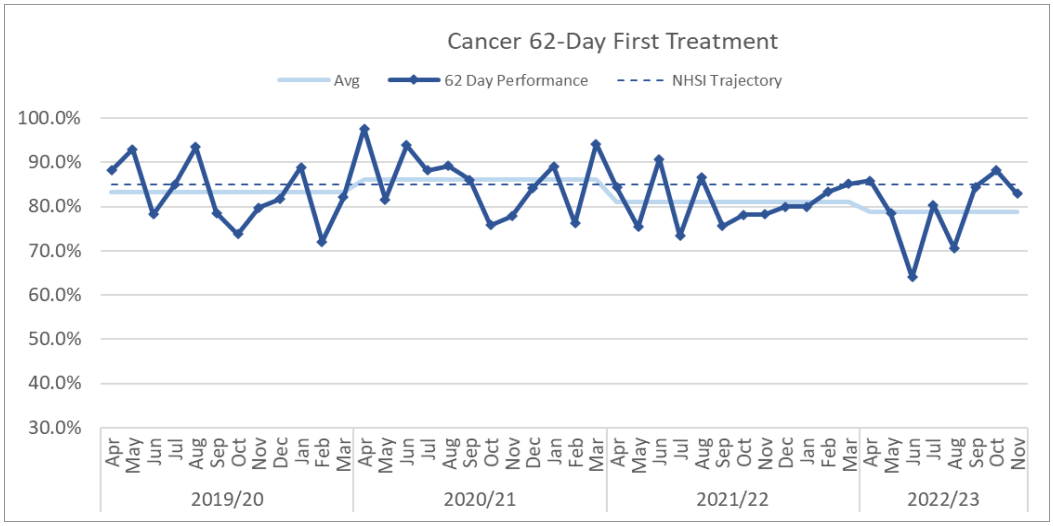
Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Overall Trust Position	70.1%	62.9%	72.2%	73.2%	73.4%	75.5%	69.9%	82.3%	76.4%	71.8%	70.6%	78.4%	72.6%	71.0%	69.8%	73.9%	69.8%
Breast	97.9%	94.4%	99.5%	94.1%	86.1%	86.5%	92.5%	97.2%	94.6%	96.3%	96.2%	98.3%	98.5%	97.5%	96.9%	99.0%	98.4%
Gynaecology	70.4%	62.2%	51.3%	63.9%	74.5%	84.2%	68.9%	80.7%	72.0%	59.0%	57.7%	69.9%	45.6%	72.9%	66.7%	67.5%	66.7%
Haematology	42.9%	70.0%	40.0%	28.6%	50.0%	33.3%	0.0%	75.0%	50.0%	44.4%	0.0%		75.0%	50.0%	61.5%	100.0%	55.6%
Head & Neck	70.4%	83.3%	81.3%	80.0%	69.6%	85.2%	83.3%	78.9%	73.9%	78.6%	72.4%	89.5%	84.2%	88.0%	77.3%	100.0%	89.5%
Lower GI	47.0%	40.4%	53.6%	64.6%	62.5%	56.2%	54.9%	76.4%	57.3%	56.1%	52.9%	67.5%	66.3%	51.0%	50.5%	58.3%	51.2%
Lung	81.0%	28.6%	83.3%	69.2%	84.6%	70.0%	66.7%	76.9%	76.5%	69.6%	71.4%	82.1%	80.0%	88.9%	61.5%	58.3%	73.9%
Upper GI	52.1%	48.8%	64.1%	58.8%	69.0%	69.2%	64.7%	75.4%	81.5%	64.9%	63.3%	67.6%	60.5%	45.2%	54.9%	69.2%	59.5%
Urology	63.3%	40.9%	69.0%	56.9%	63.6%	77.2%	56.8%	71.4%	71.3%	69.0%	69.1%	74.1%	67.7%	76.3%	71.6%	58.8%	62.5%

28 ay Faster Diagnosis Standard (FDS)

Recruited to additional support roles, and hold weekly meetings to escalate those patients who have not had a diagnosis or who need to be informed of their diagnosis.

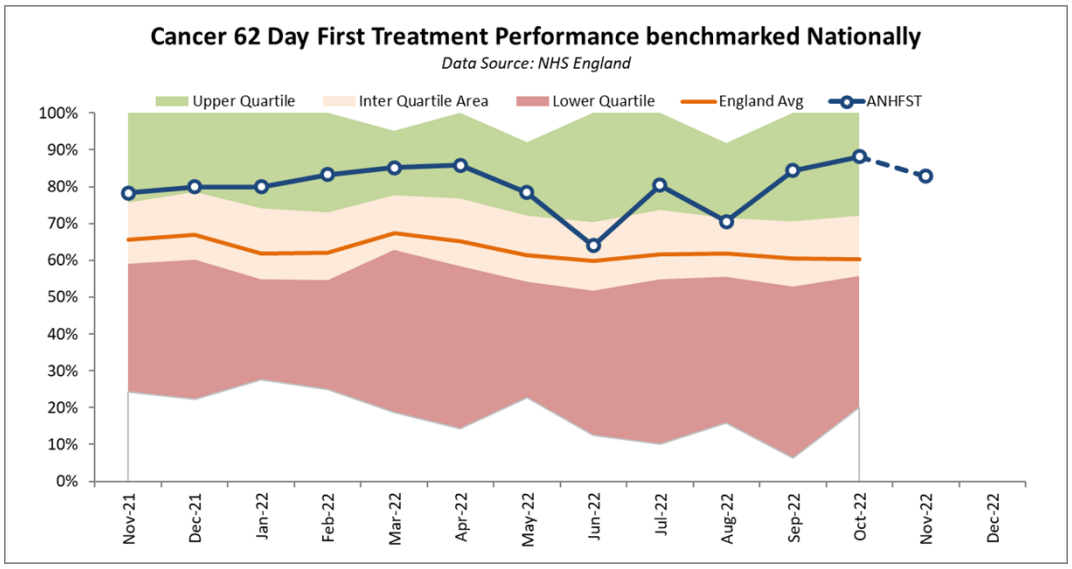
A4c Cancer 62 Day First Treatment

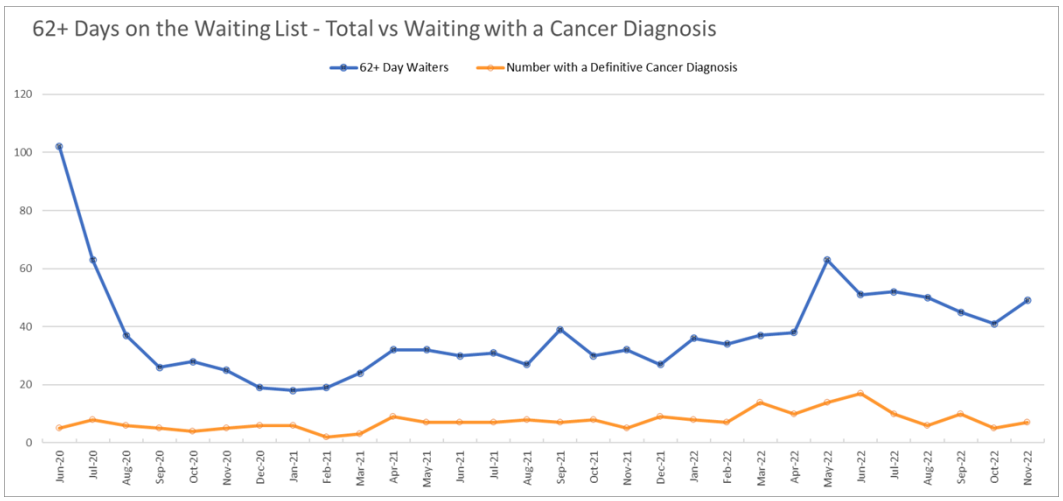
62 Day First Treatment performance (Target 85%)



62 Day First Treatment performance - National Comparison

Performance for October 2022 was achieved = 88.2%





62 Day First Treatment performance by Tumour Group

Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Overall Trust Position	73.3%	86.7%	75.6%	78.2%	78.3%	80.0%	80.0%	83.3%	85.1%	85.9%	78.4%	64.0%	80.4%	70.6%	84.4%	88.2%	82.9%
Breast	90.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	91.3%
Gynaecology	100.0%	66.7%	44.4%	75.0%	75.0%	66.7%	100.0%	100.0%	100.0%	100.0%	0.0%	33.3%	33.3%	25.0%	100.0%	100.0%	50.0%
Haematology	50.0%	50.0%	80.0%	50.0%	66.7%	40.0%	50.0%	100.0%	71.4%	100.0%	0.0%	0.0%	0.0%	100.0%	100.0%		66.7%
Head & Neck	100.0%	100.0%		100.0%			0.0%	0.0%	0.0%	100.0%		0.0%	0.0%	0.0%	0.0%		
Lower GI	50.0%	69.2%	60.0%	72.7%	36.4%	50.0%	50.0%	44.4%	62.5%	83.3%	44.4%	45.5%	57.1%	38.1%	28.6%	35.3%	46.2%
Lung	80.0%	100.0%	57.1%	80.0%	66.7%	40.0%	25.0%	100.0%	50.0%	83.3%	42.9%	66.7%	72.2%	66.7%	33.3%	50.0%	47.4%
Upper GI	0.0%	100.0%	100.0%			66.7%	100.0%	66.7%	100.0%	85.7%	100.0%	75.0%	100.0%	85.7%	100.0%	100.0%	80.0%
Urology	76.2%	87.5%	75.0%	100.0%	81.8%	100.0%	96.0%	100.0%	91.9%	84.6%	82.2%	79.5%	93.5%	100.0%	94.1%	100.0%	98.5%

Performance remains a challenge in this area with demand in site specific groups causing pressures, and patients now being frailer with multiple co-morbidities. Continued implementation of service development plans as outlined in 7.2 will support overall cancer wait time delivery.

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director, Health and Wellbeing to the meeting of Health and Overview Scrutiny Committee to be held on Thursday 19 January 2023

U

Subject: Consultation on proposed changes to adult social care non-residential charges

Summary statement: To seek the committee's comments on proposed changes to adult social care services non-residential charges from April 2023.

EQUALITY & DIVERSITY:

The Equality Act 2010 sets out the duty for public authorities to ensure that while exercising their function they are not discriminating directly or indirectly against any group or individual.

We have undertaken a detailed Equality Impact Assessment, which is attached to this report as Appendix A. Our assessment suggests that these proposals will have no detrimental impact on equality and diversity, however there is a group who may be impacted on financially, and we have put in place mitigations, which are set out in the Equalities Impact Assessment at Appendix A. Bradford Adult Social Care services, will continue to support the needs of all groups who are currently in receipt of support, and those who may need support in the future.

Iain MacBeath
Strategic Director Health and Wellbeing

Portfolio: Healthy People and Places

Report Contact: Jane Wood, Assistant Director Commissioning and Integration
Phone: (01274) 437312
E-mail: jane.wood@bradford.gov.uk

Overview & Scrutiny Area:
Health and Social Care Overview and Scrutiny

1. SUMMARY

1.1 This paper seeks the Committee's comments on a consultation on proposed changes to Adult Social Care non-residential charges with effect from 1 April 2023. These proposed changes are in addition to the annual inflation uplift applied to charges from April each year.

1.2 This is a targeted consultation with people identified as being directly impacted. There are currently 504 people who use social care services who have been financially assessed as having the means to pay for the full cost of their care. In addition, the consultation will also contact people identified by our operational social work teams as likely to be entering the service in the coming months. If consultation is approved, the data will be re-run as at 30 November 2022 to identify any changes to ensure only those impacted are included in the consultation.

1.3 These changes are part of the preparatory work for the Government's adult social care charging reforms, albeit the Government announced these reforms would be delayed to October 2025 in the Chancellor's autumn statement.

2. BACKGROUND

2.1 The Care Act 2014 is the primary legislation providing the single legal framework for charging for care and support, with the Care and Support Regulations governing the scope of 'local authorities' power to charge for meeting eligible needs and for financial assessments under the primary legislation.

2.2 Bradford's Non Residential Care Services Policy sets out the Councils approach to delivery of the requirements set out in the Care Act 2014.

2.3 The proposed consultation relates to charging service users who have been assessed as having the means to pay, the actual cost to the Council for their social care services, as opposed to a subsidised rate as at present. In the financial assessment any disability related costs are taken into account. These are the extra costs incurred by a service user to meet a specific need due to a medical condition or disability.

2.4 These proposed changes will impact directly on two cohorts of Adult Social Care service users:

i. those termed 'full-cost-payers' who have assets and savings above the current capital threshold of £23,250.
ii. those who are not currently charged at the maximum level of their financially assessed contribution.

2.5 The number of service users impacted and the cost of their packages of care and support are based on data at August 2022. As care packages can change for a variety of reasons: a service user is no longer receiving a service or following a care review and/or a financial assessment review, the number of hours and their financial assessed contribution could change this data will be refreshed at the end of November to ensure any changes are picked up.

2.6 The proposed changes to charging are:

2.6.1 **Charge all 'Full-Cost Payers' (those with eligible needs and assets above the current capital limit of £23,250) the actual cost of their services.**

- The legislation is clear when choosing to charge for care and support services an authority must **not** charge more than the cost it incurs in meeting the assessed needs of the service user.

- The Council currently has 385 services users classed as 'full-cost payers' who have asked the council to commission non-residential care and support services on their behalf.

- These service users have no 'maximum assessed contribution' as they are above the current capital limit of £23,250 and so have to contribute fully to the cost of their care and support.

- These service users have asked the Council to commission their care, although as 'full-cost payers' or 'self-funders' the Council currently has no legal obligation to commission care on their behalf.

- The Council currently charges all service users at a historical nominal cost for services which has not been uplifted each year with inflation. This is not the 'actual' cost of the services to the Council. The actual cost is more than the nominal cost, by 36.8% for the majority of services based on the current level of charges and costs i.e. those for the 2022/23 financial year. The Council is effectively subsidising the cost of these services.

2.6.2 **Charge all service users the actual cost of their services – this will impact on those not currently paying up to the assessed maximum contribution.**

- The Council could not have differential charges for full-cost payers and service users who make a partial contribution to the cost of their care. It would therefore be necessary if considering the introduction of charges based on actual costs to apply this increase to all service users.

- The Council currently has 119 services users who make a contribution to the cost of their care but do not pay the 'full-cost', receiving a total of 566.5 hours of care and support per week (this is predominantly Home Care). For 42 service users the increase would be capped at their maximum assessed contribution, for 77 it would be the full 36.81% increase. Further detail is provided in Tables 4 -5 in Appendix B along with a summary of the weekly increase in charges per week.

2.7 New Charging Reforms, as set out in Appendix C, will be introduced in October 2023 and these changes will reset and prepare CBMDC for the implementation of those new regulations.

2.8 The Council is proposing it charges the actual cost of these services from April 2023. While the Council has the powers to charge at the 'actual' cost given the percentage increase, it is proposing to consult with those directly impacted.

2.9 Table 1 sets out the proposed consultation actions and timelines.

Table 1:

	Activity	Description	Timescale
1	Formal consultation begins		13th Dec 2022
2	Communication and information sharing with service users	• Letters to be sent out to the current cohort of service user providing an explanation of the proposed changes and description of the impact on them as individuals. • The letter will also include a contact email and phone for the service user or their carer/advocate to follow up for additional information. • Each person will be offered a new care assessment, a new financial assessment and welfare benefits advice in case any of these change the value of their contribution.	13th Dec 2022
3	Communication and information sharing with community groups	• Information related to the changes to be shared with community organisations who provide welfare advice support. • This will include material that summarises the changes, and the implications for individuals and what support is available for them. • Probably worth considering setting up a one of briefing session with this cohort.	13th Dec 2022
4	Follow up calls with service users	• Financial Service staff to make outbound calls to those service users who have not responded to the letter. • We will use this opportunity to explain the changes, undertake a financial assessment reviews, including a review of any disability related expenditure and provide benefit advice for them and their families	19th Dec to 18th Jan 23
5.	Formal consultation ends		3rd Feb 23
6.	Consultation feedback	• Draft report for Executive, summarising the findings from the consultation exercise and recommending change to the council's charging policy and procedure. • Report received for decision at the Council's Executive on 21 February 2023 for implementation from April 2023.	10th Feb 23

3. OTHER CONSIDERATIONS

3.1 A financial review and a benefits review will be offered to those directly affected. A Care Act reassessment will be completed on request.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 There are no direct financial implications arising from the request to consult on the proposals contained within this report. A further report on the outcome of consultation will be presented to the Executive in February. If accepted these proposals could generate additional income / cost avoidance of up to £1.255M per annum.

5. LEGAL APPRAISAL

5.1 The changes are designed to comply with the Council's obligations under the Care Act 2014 and the Care and Support Statutory Guidance.

6. OTHER IMPLICATIONS

6.1 **HUMAN RIGHTS ACT**

This decision could be considered to engage Article 8 (Right to Family and Private Life) and Article 14 (Protection from discrimination) and all steps available are being taken to ensure that the process will be compliant.

7. OPTIONS

7.1 The Care Act 2014 sets out that individuals are expected to meet the full cost of their care unless their financial assessment sets out they need to make a lesser or a nil contribution towards their care. Under the Care Act 2014 legislation the Council has discretion to:

- Set a minimum income guarantee above the statutory rate.
- Set charges as a percentage of service users maximum disposable income.
- Apply a weekly maximum cap on charges.

7.2 All of these options would reduce income to the Council from Adult Social Care charges which would have an adverse impact on spending. Non-statutory preventative services may need to be reduced which would be detrimental to those who rely on such services to remain healthy in their own homes and communities.

7.3 The option proposed in this paper to be consulted on means that people who have been financially assessed as having the ability to pay for their care do so in full, until such a time as their assets fall below the Government threshold. This will also maximise their contribution towards the social care cap proposed as a new reform by the Government.

8. RECOMMENDATIONS

8.1 That the Committee comments on the proposals as part of the wider consultation exercise being undertaken by the Health & Wellbeing Department, ensuring that due regard is made to the Council's public sector duty as set out in the Equality Act 2010.

8.2 That the Committee's remarks be reported back to the Executive when making a decision on this issue at its meeting in February 2023.

9. APPENDICES

Appendix A Equality Impact Assessment

Appendix B Summary Data on impact for 'full-cost payers'

Appendix C Summary Data for services users not paying at their maximum assessed contribution.

Appendix D Proposed Social Care Charging Reforms.

10. BACKGROUND DOCUMENTS

- Care Act 2014.
- Care Act Care and Support Statutory Guidance.
- Regulations 2.3. Care and Support (Charging and Assessment of Resources) Regulations 2014 (SI 2014/2672) ("2014 Regulations").
- CBMDC Community Care Contribution Policy
- DHSC Draft Operational Guidance to Implement a Life time cap on care

Appendix B

Table 1: Summary of Full-Costers Impacted

Type of Service	No of Service Users	Number of Hours weekly (includes Day Care and Timeout sessions)
Double Handed Home Care	51	572.75
Home Care	313	2,854.82
Extra Care	1	1.25
Timeout	6	34.5
Day Care	9	14
Supported Living	5	201.45
Fill Cost Payers	**385**	**3,678.77**

Table 2: Number of Service Users Impacted by band of weekly cost increases

Weekly Rate Increase £	Service Users/Packages Impacted
< 10	24
10 -19	77
20 - 49	133
50 - 99	124
100 - 199	39
200 - 299	3
> 300	3
Total	403

19 service users receive more than 1 care type

Table 3: Split of 'Full-Cost Payer' Service User Hours

Hours	Service User	Comments
<5	115	includes 5 services
5>10	137	includes 1 service
10.5 - 20	145	includes 12 with 2 services
22 - 55	3	2 Home Care and 1 Supported Living
>55	3	Supported Living and one ISF
Total	**403**	19 service users receive more than 1 service

Appendix C

Table: 4 Summary of service users not at their financially assessed maximum contribution.

Type of Service	Number	Number of Hours weekly inclu Day Care and Timeout		Number of Service Users Impacted	
Double Handed Home Care	1	3.5		Increase capped at Maximum Assessed Contribution	42
Day Care Sessions	2	2		Does not reach Maximum Assessed Contribution	77
Home Care	116	561			
Total	**119**	**566.5**			**119**

Table 5: Number of Service Users Impacted by band of weekly increase

Weekly Rate Increase £	Service User/Packages Impacted
< 10	32
10 -19	29
20 - 49	52
50 - 99	6
100 - 199	0
200 - 299	0
> 300	0
Total	**119**

Appendix D

Charging Reforms

1.1 It is proposed that from October 2025, the way people pay for their care and support will change. The key changes of the Social Care Charging Reform mean:

- No one will have to pay more than £86,000 for their personal care costs in their lifetime.
- If you have less than £100,000 in savings and assets, you may be able to access financial support from the local authority to meet your eligible care costs.
- The council can arrange your care and support if you want us to, which can give you a choice of better value care.

1.2 There is a programme of work around assessing the implications of the proposed changes for the Council and working to prepare for these changes.

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City of Bradford Metropolitan District Council

www.bradford.gov.uk

Equality Impact Assessment Form

Reference –

Department	Adult & Community Services	**Version no**	3.0
Assessed by	Bev Winter	**Date created**	11.10.22
Approved by	Iain Macbeath	**Date approved**	12.11.22
Updated by	Bev Winter	**Date**	05.01.23
Approved by	Iain Macbeath	**Date**	07.01.23

Section 1: What is being assessed?

1.1 Name of proposal to be assessed:

Changes to Adult Social Care Non Residential Charges prompted by the Government's Adult Care Reform agenda.

1.2 Describe the proposal under assessment and what change it would result in if implemented.

1.2.1 **BACKGROUND**

The Care Act 2014 is the primary legislation providing the single legal framework for charging for care and support, with the Care and Support Regulations governing the scope of 'local authorities' power to charge for meeting eligible needs and for financial assessments under the primary legislation.

1.2.2 **PROPOSAL**

a) We have undertaken a refresh of the Council's Adults Social Care Non Residential Care Services Charging Policy, which sets out the Councils approach to how we charge for services in accordance with the duties set out in the Care Act 2014.

b) The refresh of the policy includes a proposal to charge service users the actual cost to the Council for their services. Currently service users pay a reduced amount, and the difference is topped up by the Council through a subsidy.

The Council is having to make these changes due to the significant increase in the cost of everything from food, electricity, fuel, which has put a major pressure on the Council's budget.

c) The Council is legally obliged to consult with those that will be affected by the changes we are proposing, which includes the following cohorts:

I. those termed 'full-costers' and have assets above the current capital threshold of £23,250.

II. those who are not currently charged at the maximum level of their financially assessed contribution.

1.2.3 **SCALE OF IMPACT**

a) The Council's Department of Health and Wellbeing is responsible for the provision of care and support under the Care Act 2104, and its strategic and assistant directors have delegated powers to formulate and implement the financial assessment and charging arrangements that are required under the Assessment Regulations. These arrangements will be formulated in a refreshed policy document **entitled the Charging Policy for Non-Residential Care Services for Adults.**

b) The Council recognises that the implementation of the refreshed policy will result in changes to the financial assessment arrangements for all affected service users and in the charges that they pay for non-residential care services provided either by the Council or by a third party.

c) The table outlined below provides a summary for both of the cohorts identified in paragraph 1.2.2.c above. It needs to be noted that the number of service users impacted and the cost of their packages of care and support are based on data at August 2022. (this will be updated just before the consultation commences).

d) It also should be noted that as packages can change for a variety of reasons: a service user is no longer receiving a service or following a care review and/or a financial assessment review, the number of hours and their financial assessed contribution could change this data will be refreshed at the end of November to ensure any changes are picked up.

Charge all 'Full-Cost Payers' (those with eligible needs and assets above the current capital limit of £23,250) the actual cost of their services.
• The legislation is clear when choosing to charge for care and support services an authority must **not** charge more than the cost it incurs in meeting the assessed needs of the service user. • The Council currently has 385 services users classed as 'full-cost payers' who have asked the council to commission non-residential care and support services on their behalf. • These service users have no 'maximum assessed contribution' as they are above the current capital limit of £23,250 and so have to contribute fully to the cost of their care and support. • These service users have asked the Council to commission their care, although as 'full-cost payers' or 'self-funders' the Council currently has no legal obligation to commission care on their behalf. • The Council currently charges all service users at a historical nominal cost for services which has not been uplifted each year with inflation. This is not the 'actual' cost of the services to the Council. The actual cost is more than the nominal cost, by 36.8% for the majority of services based on the current level of charges and costs i.e. those for the 2022/23 financial year. The Council is effectively subsidising the cost of these services. • This will impact 385 service users currently receiving a total of 3,687.77 hours of care and support per week. There are 403 packages of care impacted (19 service users receive more than one service) with increases ranging from less than £10 per week up

to in excess of £300 per week for 3 service users.

- Further detail is provided in tables outlined below, along with a summary of the number of hours received per week e.g. 115 of these service users receive less than 5 hours of care per week while 3 receive more than 55 hours of care per week.

Table 1: Summary of Full-Costers Impacted

Type of Service	No of Service Users	Number of Hours weekly (includes Day Care and Timeout sessions)
Double Handed Home Care	51	572.75
Home Care	313	2,854.82
Extra Care	1	1.25
Timeout	6	34.5
Day Care	9	14
Supported Living	5	201.45
Fill Cost Payers	**385**	**3,678.77**

Table 2: Number of Service Users Impacted by band of weekly cost increases

Weekly Rate Increase £	Service Users/Packages Impacted
< 10	24
10 -19	77
20 - 49	133
50 - 99	124
100 - 199	39
200 - 299	3
> 300	3
Total	403

19 service users receive more than 1 care type

Charge all services users the actual cost of their services – this will impact on those not currently paying up to the assessed maximum contribution.

- The Council could not have differential charges for full-cost payers and service users who make a partial contribution to the cost of their care. It would therefore be necessary if considering the introduction of charges based on actual costs to apply this increase to all service users.
- The Council currently has 119 services users who make a contribution to the cost of their care but do not pay the 'full-cost' receiving 572.75 hours of care and support per week (this is predominantly Home Care).
- For 42 service users the increase would be capped at their maximum assessed contribution, for 77 it would be the full 36.81% increase. The table below provides a more detail breakdown.

Table: 3 Summary of service users not at their financially assessed maximum contribution.

Type of Service	Number	Number of Hours weekly inclu Day Care and Timeout		Number of Service Users Impacted	
Double Handed Home Care	1	3.5		Increase capped at Maximum Assessed Contribution	42
Day Care Sessions	2	2		Does not reach Maximum Assessed Contribution	77
Home Care	116	561			
Total	**119**	**566.5**			**119**

Table 4: Number of Service Users Impacted by band of weekly increase

Weekly Rate Increase £	Service User/Packages Impacted
< 10	32
10 -19	29
20 - 49	52
50 - 99	6
100 - 199	0
200 - 299	0
> 300	0
Total	**119**

1.2.5 **IMPACT BY PROTECTED CHARACTERISTIC**

a) The Council also has a legal obligation to undertake an objective assessment of the impact of these changes upon existing and future service users in order to identify whether that impact will have a significant adverse effect upon them, and whether that effect may directly or indirectly be due to, relate to or be on the grounds of their (or another person) possessing a protected characteristic as defined within the Equality Act 2010.

b) Our initial assessment of the service users that are likely to be affected by the New Charging Policy fall into the following range:

- All over 18 years old.
- Some of them are over 60 years old.
- All of them require care and support to meet their assessed needs under the Care Act 2014.
- They all possess various degrees of vulnerability and may be disabled under the Equality legislation, or lack mental capacity for a variety of purposes as defined by the Mental Capacity Act 2006 or the Mental Health Act 1983.

- Their gender, sexual orientation ethnicity and religion is varied but has not been specifically identified within the cadre of service users that has been assessed under the policy for the purposes of this report.

c) The protected characteristics of the effected cohort are outlined in the tables below:

Full Costers	Male	Female	TOTAL
Sex	**152**	**233**	**385**
Age			
Under 25	0	0	**0**
Working Age	16	9	**25**
Older Person	136	224	**360**
TOTAL	**152**	**233**	**385**
Race Working Age			
Asian/Asian British	0	1	**1**
Black/African/Carribean/Black British	0		**0**
Mixed/Multiple	2	2	**4**
Other Ethnic Group	0		**0**
Undeclared/Not Known	0	1	**1**
White	14	5	**19**
TOTAL Working Age	**16**	**9**	**25**
Race Older Person			
Asian/Asian British	5	5	**10**
Black/African/Carribean/Black British	3	3	**6**
Mixed/Multiple	20	35	**55**
Other Ethnic Group	4	5	**9**
Undeclared/Not Known	0	3	**3**
White	104	173	**277**
TOTAL Older Person	**136**	**224**	**360**
TOTAL All Ages	**152**	**233**	**385**

Service Users Not At Maximum Assessed Financial Contribution	Male	Female	TOTAL
Sex	**56**	**63**	**119**
Age			
Under 25	0	1	**1**
Working Age	24	11	**35**
Older Person	32	51	**83**
TOTAL	**56**	**63**	**119**
Race Under 25			
Asian/Asian British	0	0	**0**
Black/African/Carribean/Black British	0	0	**0**
Mixed/Multiple	0	0	**0**
Other Ethnic Group	0	0	**0**
Undeclared/Not Known	0	0	**0**
White	0	1	**1**
TOTAL Under 25	**0**	**1**	**1**
Race Working Age			
Asian/Asian British	1	1	**2**
Black/African/Carribean/Black British	1	0	**1**
Mixed/Multiple	1	3	**4**
Other Ethnic Group	0	0	**0**
Undeclared/Not Known	0	1	**1**
White	21	6	**27**
TOTAL Working Age	**24**	**11**	**35**
Race Older Person			
Asian/Asian British	2	2	**4**
Black/African/Carribean/Black British	0	2	**2**
Mixed/Multiple	5	9	**14**
Other Ethnic Group	0	0	**0**
Undeclared/Not Known	0	3	**3**
White	25	35	**60**
TOTAL Older Person	**32**	**51**	**83**
TOTAL All Ages	**56**	**62**	**119**

The changes to this policy are not expected to significantly impact on the following groups:

Protected Characteristics		Charge all 'Full-Cost Payers' (those with eligible needs and assets above the current capital limit of £23,250) the actual cost of their services.	Charge all services users the actual cost of their services – this will impact on those not currently paying up to the assessed maximum contribution.
Age	Under 25	**0**	**1**
	Working Age	**25**	**35**
	Older People	**360**	**83**
Disability			
Gender reassignment			
Race		**As set out in the above tables**	**As set out in the above tables**
Religion/Belief			
Pregnancy and maternity			
Sexual Orientation			
Sex		**As set out in the above tables**	**As set out in the above tables**
Marriage and civil partnership			
Low income / low wage			

1.2.6 CONSULTATION AND APPROVAL

a) At its meeting on 6th December 2022, the Bradford Council's Executive will be considering the draft Charging Policy, and this Equality Impact Assessment and based on these deliberations will consider whether to approve (or not) that the new policy is opened up for consultation with key stakeholders ensuring that due regard is made to the Council's public sector duty as set out in the Equality Act 2010.

b) Subject to approval the Consultation will start on 13th December and will close on the 3rd Feb 2022.

Section 2: What the impact of the proposal is likely to be

The Equality Act 2010 requires the Council to have due regard to the need to-

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

2.1 Will this proposal advance equality of opportunity for people who share a protected characteristic and/or foster good relations between people who share a protected characteristic and those that do not? If yes, please explain further.

Yes. The provision of more cost effective and sustainable non-residential care services will facilitate the integration of persons with disabilities into the community and will enable older persons to gain greater access to community services and resources.

It will enable them to participate in the broader social milieu outside their homes and so improve their opportunities to access services (including services that may lead to employment) and foster good relations between different groups of service users by ensuring equality and transparency of service access and with the local community.

2.2 Will this proposal have a positive impact and help to eliminate discrimination and harassment against, or the victimisation of people who share a protected characteristic? If yes, please explain further.

Yes, see section 2.1.

Discrimination and harassment may include unintended exclusion from opportunities or isolation from family, friends and the community. By securing on-going equal access to non-residential services the policy will reduce the potential for such exclusion and isolation.

2.3 Will this proposal potentially have a negative or disproportionate impact on people who share a protected characteristic? If yes, please explain further.

Yes, our initial assessment outlined in section 1.2.5 above shows that the proposed changes to charging for the two cohorts set out in paragraph 1.2.2. have a disproportionate adverse impact on a total of 504 service users receiving a total of 4,254.27 hours.

We have assumed that there is a high probability that people receiving a social care service will have a disability under the Equality Act 2010, and that there is an unquantifiable negative correlation between possessing severe and life limiting disabilities and the ability to earn or acquire savings.

- Older people
- Working age adults that have more income and
- Young people under the age of 25.

Analysis of impact:

2.4 Please indicate the level of negative impact on each of the protected characteristics?

(Please indicate high (H), medium (M), low (L), no effect (N) for each)

Protected Characteristics:	Impact
Age	H
Disability	H
Gender reassignment	N
Race	L
Religion/Belief	N
Pregnancy and maternity	N
Sexual Orientation	N
Sex	M
Marriage and civil partnership	N
Additional consideration:	
Low income/low wage	M

2.5 How could the disproportionate negative impacts upon the affected groups of service users be mitigated or eliminated?

2.5.1 The current charging policy ensures that individual service users, including those with limited income, are not required to contribute more than they can reasonably afford. That principle will not change under the refreshed charging policy and all existing service users will have a new needs assessment / review, financial assessment with help to maximise benefits, review of Disability Related Expenditure and affordability of any contribution. There is also an appeals process if the service user cannot afford any newly assessed contribution.

2.5.2 Where the assessment process under the refreshed policy identifies a change in service provision we will work with the service user and their family members, carers and advocates to support the implementation of the new charges. If we do agree to take a phased approach, then we will need to add this in here.

Section 3: What evidence you have used?

3.1 What evidence do you hold to back up this assessment?

See section 2.3

3.2 Do you need further evidence?

A new financial assessment would be needed for all existing service users to ensure that we are using the most up to date financial information to determine the new charging costs.

Section 4: Consultation Feedback

4.1 Results from any previous consultations

The main message from the consultation undertaken in 2016 was around the potential disproportionate impact on low income groups and the need for robust mitigation actions to be put in place.

4.2 Your departmental feedback

When people are financially assessed their outgoings including home maintenance are taken into account. People can also appeal against a decision if they feel they cannot afford to pay.

The basis of the proposal is that people are assessed in line with most other local authorities and based on people's assessed ability to pay. The current policy has a system of appeal in place and this will also continue to be the case.

The intention and practice continues to be the equitable application of all Council policies

4.3 Feedback from current consultation

N/A

4.4 Your departmental response to this feedback – include any changes made to the proposal as a result of the feedback

N/A

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Director of Legal and Governance to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 17 January 2023

V

Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2022/23

Summary statement:
This report presents the Committee's work programme 2022/23

Portfolio:

Healthy People and Places

Report Contact: Caroline Coombes
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E-mail:
caroline.coombes@bradford.gov.uk

1. Summary

1.1 This report presents the Committee's work programme 2022/23.

2. Background

2.1 Each Overview and Scrutiny Committee is required by the Constitution of the Council to prepare a work programme (Part 3E – Overview and Scrutiny Procedure Rules, Para 1.1).

3. Report issues

3.1 **Appendix A** of this report presents the work programme 2022/23. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over coming year.

3.2. Best practice published by the Centre for Public Scrutiny suggests that 'work programming should be a continuous process'[1]. It is important to regularly review work programmes so that important or urgent issues that come up during the year are able to be scrutinised. In addition, at a time of limited resources, it should also be possible to remove projects which have become less relevant or timely. For this reason, it is proposed that the Committee's work programme be regularly reviewed by Members throughout the municipal year.

4. Options

4.1 Members may wish to amend and / or comment on the work programme at **Appendix A**.

5. Contribution to corporate priorities

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2022/23 reflects the priority outcomes of the Council Plan, in particular, 'Better Health, Better Lives' and 'Living with Covid-19'[2]. It also reflects the guiding principals of the Joint Health and Wellbeing Strategy for Bradford and Airedale 'Connecting people and place for better health and wellbeing'.

6. Recommendations

6.1 That the Committee notes the information in **Appendix A** and considers any amendments or additions it may wish to make.

6.2 That the Committee notes that the March meeting will take place on **Wednesday 22 March 2023**.

6.3 That the Work Programme 2022/23 continues to be regularly reviewed during the year.

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[1] Hammond, E. (2011) *A cunning plan?* p. 8, London: Centre for Public Scrutiny
[2] Our Council Plan: Priorities and Principles 2021-25 https://www.bradford.gov.uk/councilplan

7. **Background documents**

None

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix A** – Health and Social Care Overview and Scrutiny Committee work programme 2022/23

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Appendix A

Democratic Services - Overview and Scrutiny

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 16th February 2023 at City Hall, Bradford			
Chair's briefing 01/02/23 Report deadline 06/02/23			
1) Respiratory Health in Bradford District	Update	Jorge Zepeda	Resolution of 22 November 2018 to have an update in 2 years
2) 0-19 Children's Public Health Services	Update on performance with Bradford District Care Trust	Contact: Liz Barry	Resolution of 23 June 2022
3) Hospital discharges/NHS/ Adults/Finance update	Referral from Corporate OSC - 10 Nov 2022	Iain Macbeath	Resolution of 24 November 2022
Wednesday, 22nd March 2023 at City Hall, Bradford			
Chair's briefing 08/03/23 Report deadline 13/03/23			
1) Adult Autism	The Committee has resolved its expectation that 80% (256) of the projected number of assessments will have been delivered by March 2023 Report to also include a plan to ensure the sustainability and continued improvement of the service	Walter O'Neill	Resolution of 17 March 22
2) Health & Wellbeing Commissioning Update and Intentions - Adult Social Care 2023	Annual report	Contact: Holly Watson	Resolution of 17 March 22
3) ICS/ICB/ICP update	Placed-based Lead and Partnership independent chair to be invited to attend	Contact: James Drury	

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